ISLAND RESPIRATORY SPECIALISTS
IRS

Charlottetown: 902-892-2828
Summerside: 902-436-9633

Please Fax: 1-888-794-7979
or Email: office@irspei.ca

Referral Form

Patient Information: (please print)

Name: _____

D.O.B. _____ PHN: _____
m / d / y

Address: _____

Phone: _____ Cell: _____

Email: _____

Diagnosis:

- ☐ COPD
- ☐ Diabetes
- ☐ Asthma
- ☐ Cardiac Disease
- ☐ Hypertension
- ☐ Arrhythmia
- ☐ Cancer
- ☐ ILD
- ☐ Other: _____

Referring Physician: _____
(Please Print)

Physician's Phone #: _____

Sleep Therapy

☐ **Level III - Home Sleep Diagnostic Test for OSA**
If result is Moderate to Severe, proceed to CPAP Trial
☐ **Yes**

☐ **CPAP Therapy Trial**
(OSA Diagnosis confirmed Moderate to Severe)
- ☐ Auto CPAP Trial
- ☐ Auto BiPAP Trial
- ☐ Other _____

☐ **Level IV - Nocturnal Oximetry – HR/Sp02**

Oxygen Therapy:

☐ **Oxygen Assessment**
(Includes Resting/Walking Oximetry & Respiratory Assessment)

☐ **Home Oxygen Therapy:**
- ☐ Oxygen Concentrator ___ l/min
- ☐ Portability ___ l/min
- ☐ Usage ___ hrs/day

Physician's Signature: _____

Date: _____

STOP-Bang Questionnaire

Obstructive Sleep Apnea Screening Tool

1. **Snoring:** Do you snore loudly (loud enough to be heard through closed doors)?
   ☐ **Yes** ☐ **No**
2. **Tired:** Do you often feel tired, fatigued, or sleepy during daytime?
   ☐ **Yes** ☐ **No**
3. **Observed:** Has anyone observed you stop breathing during your sleep?
   ☐ **Yes** ☐ **No**
4. **Blood Pressure:** Do you have or are you being treated for high blood pressure?
   ☐ **Yes** ☐ **No**
5. **BMI:** BMI more than 35 kg/m2 ?
   ☐ **Yes** ☐ **No**
6. **Age:** Age over 50 years old?
   ☐ **Yes** ☐ **No**
7. **Neck circumference:** Neck circumference greater than 40 cm/16" ?
   ☐ **Yes** ☐ **No**
8. **Gender:** Male?
   ☐ **Yes** ☐ **No**

High risk of OSA: Yes to 3 or more questions

Low risk of OSA: Yes to less than 3 questions

Chung F et al. Anesthesiology 2008; 108:812-21.